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Written Testimony of Nicolas Terry, Hall Render Professor of Law & Executive Director, Hall Center for Law and Health, Indiana University Robert H. McKinney School of Law

for

Hearing on “Preventing and Treating Opioid Misuse Among Older Americans”

United States Senate Special Committee on Aging, May 23, 2018

Statement to the U.S. Senate Special Committee on Aging
Nicolas P. Terry, Hall Render Professor of Law
& Executive Director, Hall Center for Law and Health
Indiana University Robert H. McKinney School of Law, May 23, 2018

Thank you Chairman Collins, Ranking Member Casey, and Committee Members for this opportunity to speak with you today. I am a Professor of Law at Indiana University. I serve on the Scientific Leadership team for the University's \$50 million "Responding to the Addictions Crisis Grand Challenge" initiative and, with colleagues from our school of law and school of public health, I am engaged in a research project designed to identify legal and policy barriers to effective opioids interventions.¹

My testimony will address 3 issues:

- Characteristics of the Addictions Crisis
- Responses to the Crises
- Complicating Factors involving the near-elderly and elderly

1. Characteristics of the Addictions Crisis

I have to admit that, originally, our work did not include an ageing lens, instead focusing on harm reduction and halting the deaths of the young or the middle-aged with Substance Use Disorders (SUD). Broadening the discussion is an important reminder that the opioid crisis is continually morphing. What began as a prescription drug crisis (first opioids, increasingly stimulants²) among medical users is now in the shadow of an illegal drug crisis (first, fentanyl, now also cocaine, and methamphetamine³) affecting non-medical users. What began as a crisis heavily impacting white, rural middle-aged persons now is affecting urban areas and people of color.⁴

It should be no surprise, therefore, that older adults also are suffering. Older adults make up about 25% of the long-term opioid users⁵ and Medicare beneficiaries are the fastest growing

¹ Legal and Policy Best Practices in Response to the Substance Abuse Crisis: A Preliminary Report, March 30, 2018, <https://grandchallenges.iu.edu/doc/iu-grand-challenges-legal-and-policy-best-practices.pdf>.

² Charles P. Vega, The Next Wave of Addiction, Medscape, May 16, 2018 (noting "In 2016, first-time recreational use of stimulants outpaced first-time opioid use).

³ DRUG ENFORCEMENT ADMINISTRATION, 2017 NATIONAL DRUG THREAT ASSESSMENT, DEA-DCT-DIR-040-17 (2017), <https://www.dea.gov/docs/DIR-040-172017-NDTA.pdf>. See, also, Peter Phalen et. al., *Fentanyl related overdose in Indianapolis: Estimating trends using multilevel Bayesian models*, (ADDICT. BEHAV. Forthcoming 2018), available at <https://www.sciencedirect.com/science/article/abs/pii/S0306460318301217>; Christine Vestal, *A New Meth Surge Gathers Momentum*, THE PEW CHARITABLE TRUSTS (May 18, 2017), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/05/18/a-new-meth-surge-gathers-momentum>.

⁴ Shanoor Seervai, Arnav. Shah, & Eric C. Schneider, *The U.S. Has Two Opioid Epidemics: The Federal Response Should Consider Both*, TO THE POINT (Mar. 22, 2018), <http://www.commonwealthfund.org/publications/blog/2018/mar/federal-response-to-opioids>.

⁵ Mojtabei R. National trends in long-term use of prescription opioids. *Pharmacoepidemiol Drug Saf.* 2018;27:526–534. <https://doi.org/10.1002/pds.4278>

population of diagnosed opioid use disorders.⁶ The number of seniors with SUD is predicted to double between 2004 to 2020 (1.2% to 2.4%).⁷

2. Responses to the Crises

In our research we noted positive steps taken in our state and elsewhere:

1. Making naloxone broadly available and increasing the number of persons who can administer it
2. Improving data management and public health surveillance
3. Expanding Prescription Drug Monitoring Programs and integrating them with electronic health records
4. Establishing supply-side approaches to reducing the number of opioids in circulation by placing limits on the prescription of opioids and instituting take-back and disposal programs, and
5. Increasing policing and other law enforcement efforts to reduce the supply of illegal drugs.

While perfection can be the enemy of the good, sometimes “good” is not good enough. We concluded that we could do much more, specifically:

1. Prioritize harm reduction.
 - Increase the availability of the overdose-reversal drug naloxone
 - Support the work of syringe exchange programs and first responders
 - Create more safe spaces and routes to treatment
 - Reduce stigma and mainstream the addiction state, just as we have tried to do with mental illness
2. Remove legal impediments that hold up effective responses
 - Synchronize Good Samaritan and drug paraphernalia laws
 - Better coordinate federal privacy laws
 - Make it easier for those with substance use disorder to access Medicaid services.
3. Make careful and sustaining investments in healthcare services
 - Invest in more and improved evidence-based treatment services

⁶ CMS, *Opioid Misuse Strategy*, Jan. 5, 2017, <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf>. See also Report (OEI-02-17-00250) Office of the Inspector General, *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*, 07-11-2017:

- One in three Medicare Part D beneficiaries received a prescription opioid in 2016
- About 500,000 beneficiaries received high amounts of opioids
- Almost 90,000 beneficiaries are at serious risk; some received extreme amounts of opioids, while others appeared to be doctor shopping
- About 400 prescribers had questionable opioid prescribing patterns for beneficiaries at serious risk; these patterns are far outside the norm and warrant further scrutiny.

<https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf>

⁷ Opioid Use in the Older Adult Population, <https://www.samhsa.gov/capt/tools-capt-learning-resources/opioid-use-older-adult-population>

- Pay for improved care coordination and wrap-around services such as safe housing, and make resources available to offer counseling
- Help those re-entering society avoid a cycle of addiction and incarceration.
- Innovate in providing care for children born with neonatal abstinence disease.

3. Complicating Factors involving the near-elderly and elderly

I defer to the expertise of my co-panelists on pharmacology and the nature of addiction among seniors but I would note certain heightened risk factors found in the literature:⁸

- Because of chronic pain the near-elderly and elderly likely will be longer term users of opioids
- Medication sensitivity increases with age
- Polypharmacy,⁹ including the use of benzodiazepines, sleep aids, alcohol, and marijuana, that heightens risks associated with SUD
- Drug hoarding and drug sharing
- Co-morbidities that increase the risk of missing a SUD diagnosis¹⁰
- Long-term use of opioids is more common in near-elderly and elderly population and correlates with chronic health and with populations using public rather than private insurance.¹¹
- Opioid use has been associated with fall-related injuries and death among older adults.¹²
- Risks of injury and death are substantially higher amongst older adults with opioid use disorder.¹³
- Rural older adults are dying from the opioid epidemic at a slightly higher rate than older adults generally.¹⁴

It is clear that not only do many aspects of the crisis apply equally to seniors but also some, specific, complicating considerations come into play.

1. Care Coordination Challenges

⁸ See generally Jane Tilly et al, *The Opioid Public Health Emergency and Older Adults*, Administration for Community Living, Dec. 2017, <http://www.nasuad.org/sites/nasuad/files/ODU%20issue%20brief%20final%20508%20compliant%202-8-17.pdf>.

⁹ Charlesworth, C. J., et al (2015). Polypharmacy Among Adults Aged 65 Years and Older in the United States: 1988–2010. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 70(8), 989–995. <http://doi.org/10.1093/gerona/glv013>

¹⁰ Maree, R.D., Marcum, Z.A., Saghafi, E., Weiner, D.K. and Karp, J.F., 2016. A systematic review of opioid and benzodiazepine misuse in older adults. *The American Journal of Geriatric Psychiatry*, 24(11), pp.949-963.

¹¹ Mojtabai R. National trends in long-term use of prescription opioids. *Pharmacoepidemiol Drug Saf.* 2018;27:526–534. <https://doi.org/10.1002/pds.4278>.

¹² Daoust et al., Recent opioid use and fall-related injury among older patients with trauma. *CMAJ.* 2018 Apr 23;190(16):E500-E506. doi: 10.1503/cmaj.171286.

¹³ Larney, S, et al, (2015). Mortality among older adults with opioid use disorders in the Veteran’s Health Administration, 2000–2011. *Drug and Alcohol Dependence*, 147, 32–37. <http://doi.org/10.1016/j.drugalcdep.2014.12.019>

¹⁴ William F. Benson and Nancy Aldrich, *Rural Older Adults Hit Hard By Opioid Epidemic*, *Aging Today*, Sep. 27 2017, <http://www.asaging.org/blog/rural-older-adults-hit-hard-opioid-epidemic>.

Many of the barriers to effective opioid interventions may be laid at the feet of our healthcare system. They include access problems (particularly for the very poor and the poor), high and increasing costs (including insurance costs, prescription drug costs, and cost-shifting), substandard care coordination, a frequently incoherent healthcare delivery model involving multiple types of entities and financing or reimbursement models, inadequate wraparound services, and severe deficiencies in data management and sharing.

The need for improved coordination frequently has been cited by organizations such as the National Academies of Science,¹⁵ the Agency for Healthcare Research and Quality,¹⁶ and the National Quality Forum.¹⁷ Successful care coordination has several key pillars, including “access to a range of health care services and providers,” effective communications and care plan transitions (hand-offs) between providers, a focus on the patient’s needs, the communication of “clear and simple information that patients can understand,”¹⁸ and the effective use of health information technologies.¹⁹

It is broadly recognized that many of the care coordination issues that present in the SUD context follow from the historic segregation of substance use diagnosis and treatment from mainstream healthcare delivery, with the former frequently thought of as social or criminal justice issues that should be dealt with by psychiatric hospitals or prisons.²⁰ As we now know, persons suffering from SUD (and frequent co-morbidities such as mental health diseases) are particularly vulnerable populations that in practice require additional and particularly robust levels of care coordination. These unmet needs likely are exacerbated when we combine additional co-morbidities associated with the near elderly and the elderly.

Hospital readmissions among the elderly is a useful proxy, with a higher rate of readmission among seniors with multiple symptoms such as cognitive impairment and polypharmacy.²¹ Indeed the readmissions penalty program is an attempt to make hospitals commit to wraparound services including home visits to assist vulnerable populations.”²² Perhaps the best-known case

¹⁵ See, e.g., *Improving Diagnosis in Health Care*, THE NATIONAL ACADEMIES OF SCIENCES ENGINEERING MEDICINE (Sept. 22, 2015), <http://www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx>.

¹⁶ *Care Coordination*, AGENCY FOR HEALTHCARE QUALITY AND RESEARCH, <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html> (last visited Mar. 30, 2018).

¹⁷ *Care Coordination Measures*, NATIONAL QUALITY FORUM, <http://www.qualityforum.org/ProjectDescription.aspx?projectId=73700> (last visited Mar. 30, 2018).

¹⁸ *What Is Care Coordination?*, NEJM CATALYST (Jan. 1, 2017), <https://catalyst.nejm.org/what-is-care-coordination/>.

¹⁹ *Improved Care Coordination: The Need for Better Improved Care Coordination*, HEALTHIT.GOV, <https://www.healthit.gov/providers-professionals/improved-care-coordination> (last visited Mar. 30, 2018).

²⁰ *Health Care Systems And Substance Use Disorders*, in FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH, 6-1, 6-5 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

²¹ Raval, A. D., Zhou, S., Wei, W., Bhattacharjee, S., Miao, R., & Sambamoorthi, U. (2015). 30-Day Readmission Among Elderly Medicare Beneficiaries with Type 2 Diabetes. *Population Health Management*, 18(4), 256–264, <http://doi.org/10.1089/pop.2014.0116>.

²² Joshua M. Liao et al, *Beyond Adjustments for Socioeconomic Status in Hospital Readmissions Penalties*, Harv. Pub. H. Rev. (2016), <http://harvardpublichealthreview.org/632/> (arguing hospitals should adopt “public health-minded organizational strategies” and commit “resources to out-of-hospital interventions” including food security and housing).

management/care coordination/wrap-around services model is that adopted by the Ryan White HIV/AIDS Program. The provision of medical case management, nonmedical case management, social services are key features of the program.²³ By filling gaps between existing services and because it is a “payer of last resort,” the program has been extremely successful in reducing AIDS-related mortality and morbidity.²⁴ It is a thoughtful model to follow any time we examine healthcare services for vulnerable populations.

2. Access

Our research in Indiana suggest that persons with SUD face acute problems in accessing healthcare services. Our state is not alone in facing inadequate treatment opportunities, both qualitative and quantitative. There are long waiting lists, a dearth of treatment availability in some rural areas (fewer than one in ten treatment facilities are in rural areas²⁵) and quality issues caused, for example, by facilities being detox-only or not offering a full range of evidence-based medication assisted treatments.²⁶

Approximately 23 per cent of the Medicaid population (or 15 million persons) are over 45 years of age.²⁷ CMS is highly supportive of state flexibility in Medicaid services and states are leveraging Section 1115 waiver authority to test innovations.²⁸ However, some recently approved waivers such as paperwork requirements for establishing eligibility and premium payments may disproportionately affect persons with SUD and co-morbidities.

More positively, Section 1115 waivers may be available to implement innovations in behavioral health such as suspending The Medicaid Institutions for Mental Disease (IMD) exclusion which disallows Medicaid funding of Medicaid coverage of specialized inpatient behavioral health services, reimbursing care coordination, or pay for services that address health-related social needs such as supportive housing, transportation and food.²⁹

²³ HIV Care Providers Emphasize The Importance Of The Ryan White Program For Access To And Quality Of Care
Neeraj Sood, et al, doi: 10.1377/hlthaff.2013.1297 HEALTH AFFAIRS 33, NO. 3 (2014): 394–400.

²⁴ Ryan White Part C Program: Providing Effective, Patient- Centered Medical Care to People Living with HIV/AIDS, 2014, http://www.hivma.org/uploadedFiles/HIVMA/Policy_and_Advocacy/Ryan_White_Medical_Providers_Coalition/Comments/FY%2015%20Approps_Part%20C%20Paper_Final.pdf

²⁵ William F. Benson and Nancy Aldrich, Rural Older Adults Hit Hard By Opioid Epidemic, *Aging Today*, Sep. 27 2017, <http://www.asaging.org/blog/rural-older-adults-hit-hard-opioid-epidemic>.

²⁶ Knudsen, H. K., Abraham, A. J., & Oser, C. B. (2011). Barriers to the implementation of medication-assisted treatment for substance use disorders: The importance of funding policies and medical infrastructure. *Evaluation and Program Planning*, 34(4), 375–381. <http://doi.org/10.1016/j.evalprogplan.2011.02.004>; Brendan Saloner, Colleen L. Barry, Ending the Opioid Epidemic Requires a Historic Investment In Medication-Assisted Treatment, *Journal of Policy Analysis and Management*, 2018, <https://doi.org/10.1002/pam.22047>.

²⁷ KFF, Medicaid Enrollment by Age, <https://www.kff.org/mecaid/state-indicator/mecaid-enrollment-by-age/>

²⁸ National Association of Medicaid Directors, Medicaid Section 1115 Waiver Trends in an Era of State Flexibility, Mar. 2018, <http://medicaiddirectors.org/wp-content/uploads/2018/03/Section-1115-Waiver-Trends-NAMD-Whitepaper-1.pdf>.

²⁹ Id.

3. *Undertreatment*

One of the frequent calls to action during the opioid crisis is to reduce overprescribing and overtreatment. However, as overtreatment is brought under control, the pendulum may well swing too far in the other direction. According to SAMHSA “Nearly half of older Americans suffer from a chronic pain disorder, and the incidence of chronic pain increases with age.”³⁰ Chronic pain becomes common after the age of 55 while joint pain increases exponentially thereafter.³¹ Among the elderly, 50 percent of those who live independently and 75-85 percent in care facilities suffer from chronic pain. Even today, however, “pain among older adults is largely undertreated.”³²

Denying prescription opioids to a cohort that suffers from chronic pain and, in the case of the elderly or near-elderly, has been treated for a decade or more with opioids could have serious consequences. In addition to undertreatment problems some in the cohort may turn to illicit drugs with all the negative public health connotations entailed.³³

This delicate balance between overtreatment and undertreatment highlights both the need for careful calibration of interventions and reminds us that evidence-based SUD interventions resist a “one-size fits all” model.

Conclusion

In preparing these remarks we found gaps in the data and relatively little evidence-based research discussing opioid misuse among elderly cohorts, suggesting that additional research is warranted. Once again I express my thanks to the Committee for this opportunity to address these vital issues. Going forward, I and other members of the Indiana University Grand Challenge team will be at your disposal.

³⁰ Opioid Use in the Older Adult Population, <https://www.samhsa.gov/capt/tools-capt-learning-resources/opioid-use-older-adult-population>

³¹ Prevalence and Relevance of Pain in Older Persons, Stephen J. Gibson, PhD David Lussier, MD, FRCP Pain Medicine, Volume 13, Issue suppl_2, 1 April 2012, Pages S23–S26, <https://doi.org/10.1111/j.1526-4637.2012.01349.x>

³² Seniors and Chronic Pain, MedlinePlus, Fall 2011 Issue: Volume 6 Number 3 at 15, <https://medlineplus.gov/magazine/issues/fall11/articles/fall11pg15.html>

³³ Carrie L. Wade and Cory J. Goracke-Postle, Harm Reduction Strategies For Chronic Pain Management In The Opioid Epidemic, R STREET POLICY STUDY No. 142 May 2018, <https://2o9ub0417chl2lg6m43em6psi2i-wpengine.netdna-ssl.com/wp-content/uploads/2018/05/Final-142-for-posting.pdf>.